

# Combat Psychiatry Today: From the Battle Front to the Home Front *and Back Again.....*



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# Disclaimer

The opinions expressed in this presentation are those of the author and **do not** represent the official opinion of the Uniformed Services University of the Health Sciences, the Department of the Army or the Department of Defense.



Thanks to COLs Hoge, Crow, Milliken, Cozza,  
and many many others

# General Topics

- A Brief History of Combat Psychiatry
- Deployment stresses in Iraq
- Re-integration home
- Women at War
- Surveillance
- The Way Ahead



# A Brief History of Combat Stress

- High rate of stress casualties in all wars

World War I--“shell shock”, over evacuation led to chronic psychiatric conditions, lessons learned

- World War II--ineffective pre-screening, “battle fatigue”, lessons relearned, 3 hots and a cot
- “PIES” (proximity, immediacy, expectancy, simplicity)
  - “3 hots and a cot”



# The Korean War

- Used lessons from WW I and II
- Many similarities to today



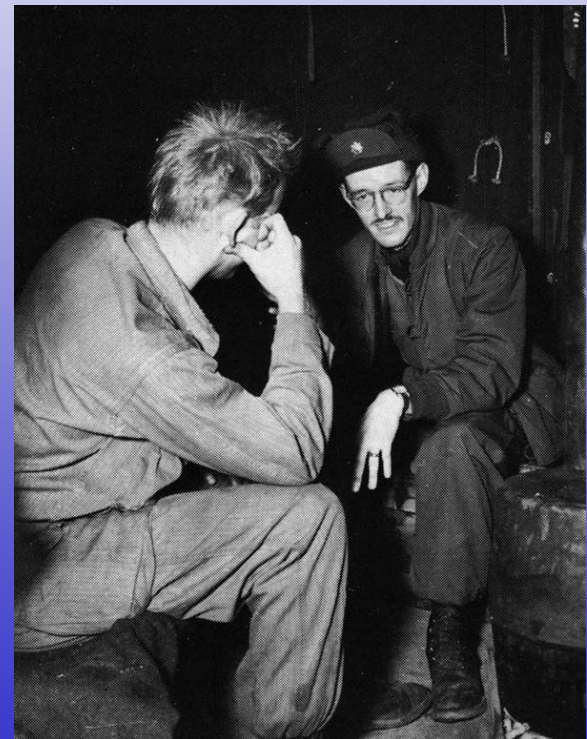
He is the average American boy,  
just under 20, who was pulled  
from his malted milks and  
basketball scores to be wounded  
in Korea.



Back Down the Ridge, WL White

After three days of such treatment...one lanky mountain boy, who had arrived trembling and sobbing that he could never go back, sat silent for a minute. Then he stood up. “Hell,” he said, “I guess somebody’s got to fight this god-damned war,” picked up his rifle and started trudging back up the trail toward the sound of the guns.

Back Down the Ridge



# History

- Vietnam
  - Misconduct
  - Drug and alcohol use
  - Post Traumatic Stress Disorder
- Desert Storm/Shield
  - “Persian Gulf illnesses”
  - Medically unexplained physical symptoms
  - Questions about exposures to toxins



# Operations Other than War

- Front line mental health treatment—PIES worked—in general, few combat stress reactions\*
  - Somalia
  - Haiti
  - Saudi Arabia
  - Cuba
  - Balkans

\*Dear John, or Jane,  
letters still caused  
problems



add a shower to the 3 hots

# 9/11



# Post-Traumatic Stress Disorder

- Reaction of fear to traumatic event
- Range of symptoms
  - Nightmares, flashbacks, hypervigilance, numbing, disassociation
- Often co-morbid with other symptoms
  - anxiety, depression, substance abuse



# Range of Deployment-Related Stress Reactions\*

- Irritability, bad dreams, sleeplessness
- Difficulty connecting to families, employers
- Behavioral difficulties
  - domestic violence, substance abuse, “road rage”,
  - suicidal, homicidal behavior
  - misconduct
- Post-traumatic stress disorder (PTSD)
- “Compassion fatigue”
- Suicide
- Homicide

\*may also occur in those non-deployed

# Primary Concerns of Women in the Military before 9/11, OIF

- Managing family and career
  - children
  - aging parents
- Reproductive Issues
  - Pregnancy, breastfeeding
- Gynecological issues
  - management in the field
- Sexual harassment and assault
  - especially in isolated pockets



# Women in the Military Now

- 15% of all active duty
- Combat support and combat service support
  - Technically not in combat roles
  - No “front lines” or safe rear in Operation Iraqi Freedom
  - Military Police, Transport, Medical
- Heavy exposure to combat, wounded soldiers, blasts, detainees
- Wounded women
  - Mothers



# Operation Iraqi Freedom

- Initial questions about weapons of mass destruction
- Rapid optempo
- Strain on families
- Continual danger for troops



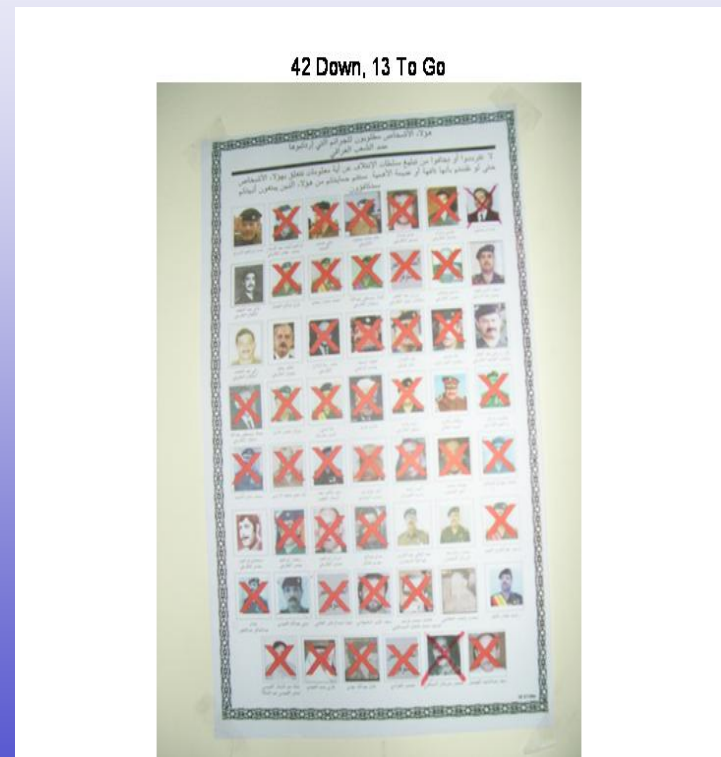
# Initial Mental Health Issues in Iraq

- Significant forward mental health presence
- Dangers of travel
- Troops not always able to travel to meet with practitioners
- Question of a suicide cluster
- Psychiatric evacuations from theater
- Medical/surgical evacuations from theater



# Mental Health Assessment Team Report 1

- Data collected by 12 person team fall 2003
- Report released spring 2004
- Covered morale, service delivery, access to mental health--deficiencies found



# The Ongoing Insurgency

- Extended deployment
- Increasing personal threats
- The scandal from Abu Ghraib
- Repeated deployments
- Casualties on all sides



# Mental Health Assessment Team II

- Deployed back to Kuwait/Iraq in August 2004
- Principle mission to focus on whether recommended changes had been implemented
- Report issued July 2005
  - improvements made



# Women in Combat

- MHAT II Report shows almost same rate of PTSD in men and women (13 and 12%)
  - Data gathered fall 2004, released 2005
- Long-term effects in women unknown at this time
  - Self-selected, resilient population
- Challenges for highly exposed personnel
  - medical
  - chaplains
  - mortuary affairs



# Back Home

- Preparation for the return
  - Educational briefings given
- Emerging data
- Risky Behaviors
  - Increased accidents,  
domestic violence, substance abuse,



# Post-Deployment Health Re-Assessment (PDHRA)

- “Honeymoon” period
- 90 to 180 days following deployment
- Active duty and reserve component
- Emphasis on behavioral health
- Implementation plan complex



# Women Warriors at Home

- Re-integration with families
- What helps
  - supportive extended families
  - community support
  - recognition of importance of mission



# and Back Again....

- Soldiers and Marines returning into theater for second or third time
- How does that effect connections with families?
- At what point do you not send Soldiers back into theater because of PTSD?
- Issues of contagion, epidemic, malingering
- Relationship to/between DoD, VA civilian providers



# High-Risk Populations

- Wounded service members and their families
- Psychiatrically ill patients
- Families of the deceased
- Medical staff and other highly exposed personnel (eg chaplains, mortuary affairs, casualty assistance officers)
- Medical Hold/holdover patients
- Isolated Reserve component



# Surveillance

- NEJM article by Hoge et al (Aug 2004) reported that about 16% of returned Soldiers had PTSD, anxiety, depression
  - Using conservative scales, also measuring impairment
  - Land-combat study, therefore primarily male subjects
- Ongoing post-deployment health screens (PDHA)
  - All returning service members
  - 3-5 % referred to behavioral health



## Issues Revealed by WRAIR study

- 16-19% of infantry Soldiers or Marines screened positive for a mental health problem when surveyed 3 to 6 months post-deployment Iraq.
- The largest increase in mental health problems post-deployment compared to pre-deployment was for post-traumatic stress disorder (PTSD) (12-15% vs. 5%).
- PTSD was co-morbid with alcohol misuse.
- Only one-third of Soldiers and Marines with mental health problems receive any professional help (including from chaplains).
- Most Soldiers with mental health problems perceive that they will be stigmatized if they receive care. Other barriers to care exist.

From Hoge et al

# Strategies

- Combat and Operational Stress Control
  - Prevention, outreach, therapy
  - “therapy by walking around”
- Treatment
  - Many effective treatments for PTSD, anxiety, depression
  - New treatment guidelines available
    - DoD-VA, APA
  - Post-deployment health guidelines
- Primary care should have central role
  - Other low-stigma easy access portals needed



# Solutions—In Progress

- Deployment Cycle Support
- Military One Source
- Community based health care organizations (CBHCOs)
- Liaison with the VA
- Post-Deployment Health Re-Assessment
- National education campaign
  - Partner with HHS (SAMSHA, NIMH)
  - The professional societies, schools
  - Academics



# ***RESET Program***



# Conclusion

- Mental health needs of our soldiers and families is critical to maintaining a resilient fighting force
- We know what should be done
- Let us put our national will to doing it *right*

